UTAH ACCIDENT & HEALTH SURVEY INSTRUCTIONS

All Fraternal, Health, Life and Property & Casualty insurers in Utah who report accident and health business on the Utah State page of the NAIC Annual Statement are required to complete and file this annual survey. All other insurers are exempt. The completed survey form should be mailed to the Utah Insurance Department **by March 1, 2003**. Submissions may also be made via email to jhawley@utah.gov. Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code Annotated § 31A-2-308. Any questions on completing this survey form should be directed to Jeff Hawley, Research Analyst at (801) 538-9684.

This survey is designed to collect accident and health data in greater detail than is reported on the Utah State page of the NAIC Annual Statement. The survey follows definitions and categories used in the NAIC Annual Statement as much as possible. All data values reported on the survey form should represent the year-end totals of the report year (December 31, 2002) and be consistent with the Utah specific data reported on the NAIC Annual Statement for 2002.

The survey form is divided into four parts. In parts I, II, and III, all data reported should represent direct insured business in the State of Utah only. In part IV, all data reported should represent administration of non-underwritten Utah medical plans only. All other types of insured business should be excluded from part IV.

Please note that direct insured business means business where the insurance company bears the underwriting risk prior to ceding or assumption and should include all Utah residents (even if your company wrote the policy in another state and the insured member later moved into Utah). If your company did not report any direct accident and health insurance business in Utah (i.e., zero reported for direct accident and health business in Utah on the Utah State page), then your company is exempt from filing the survey form.

COLUMN DEFINITIONS

PARTS I, II, or III:

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
NUMBER OF INSURED POLICIES:	For individual policies, enter the number of insured policyholders. For group policies, enter the number of certificate holders. This column is required for parts I and II only.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year for each A&H insurance category.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year for each A&H insurance category.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year for each A&H insurance category.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year for each A&H insurance category.

PART III:

CUMULATIVE MEMBER MONTHS:	Enter the cumulative year-end member months for each comprehensive hospital & medical plan category. If you report comprehensive premium, you must report member months, even if the insured members is zero at the end of the calendar year. To calculate member months, first count the number of insured members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 insured members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.

PART IV:

NUMBER OF MEMBERS:	Enter the total number of members in self-funded or insured medical plans administered by the insurer.
ADMIN. INCOME:	Enter the total dollar amount of administrative income received by the insurer for administrating self-funded or insured medical plans.
CLAIM ACTIVITY:	Enter the total dollar amount of claims processed by the insurer while administrating self-funded or insured medical plans.

SELECTED ROW DEFINITIONS

PART I:

COMPREHENSIVE HOSPITAL & MEDICAL:	Business that includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured member's primary health benefit plan. If Comprehensive Hospital & Medical is reported, part III must also be completed.
MEDICAL ONLY:	Medical only contracts such as medical only, hospital only, expense reimbursement and indemnity plans.
MEDICARE SUPPLEMENT:	Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. If Medicare Supplement is reported, part II must also be completed.
DENTAL ONLY:	Policies providing for dental only coverage issued as a stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
FEDERAL EMPLOYEES (FEHBP):	Business allocable to the Federal Employees Health Benefit Plan premium.
Title XVIII MEDICARE:	Business where a premium is collected and the insurer covers the full medical costs of Medicare subscribers.
Title XIX MEDICAID:	Business where a premium is collected and the insurer covers the full medical costs of Medicaid subscribers.
STOP LOSS:	Stop loss insurance coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product.
DISABILITY INCOME:	Policies providing coverage for loss of income resulting from a disability.
LONG TERM CARE:	Business allocable to Long Term Care coverage. If Long Term Care is reported, part II must also be completed.
CREDIT A&H:	Policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Other coverage not specifically addressed in any other columns.
TOTAL ACCIDENT AND HEALTH:	Sum total of all of the A&H categories listed previously. This line (line 14, part I) must balance with the total accident and health premium and losses reported on the Utah State page of the Annual Statement.

PART III:

INDIVIDUAL:	Insured policies issued to an individual person. Exclude individual conversion policies.
SMALL GROUP (2 to 50):	Uses HIPPA definition of small group size. Insured policies issued to a group organization.
LARGE GROUP (51 or more):	Uses HIPPA definition of large group size. Insured policies issued to a group organization.
CONVERSION:	Individual insured policies that have been converted from a group insured policy.
GRAND TOTAL COMPREHENSIVE:	Total insured comprehensive hospital & medical business in Utah. This line (line 5.0, part III) must balance with the comprehensive hospital & medical data reported on line 1, part I.

PART IV:

SELF-FUNDED MEDICAL PLANS:	This category refers to any administrative business (third party administration, administrative services only, or administrative services contract) with a self-funded or ERISA eligible employer-sponsored medical plan in the State of Utah.
INSURED MEDICAL PLANS	This category refers to any administrative business (third party administration, administrative services only, or administrative services contract) for an insured medical plan in the State of Utah other than those sponsored by the administrating insurer.

UTAH ACCIDENT & HEALTH SURVEY
DUE MARCH 1, 2003

Mail to: Attention: Jeff Hawley
Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114-6901
PH (801) 538-3800

NAIC COCODE	COMPANY		
PERSON COMPLETING FORM		TELEPHONE	REPORT YEAR **2002**

PART I: UTAH INSURED ACCIDENT & HEALTH BUSINESS ONLY (ROUND TO NEAREST DOLLAR)

	I	II	III	IV	V	VI
ACCIDENT AND HEALTH	NUMBER OF INSURED MEMBERS	NUMBER OF INSURED POLICIES	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
1. Comprehensive Hospital & Medical						
2. Medical Only						
3. Medicare Supplement						
4. Dental Only						
5. Vision Only						
6. Federal Employees (FEHBP)						
7. Title XVIII Medicare						
8. Title XIX Medicaid						
9. Stop Loss						
10. Disability Income						
11. Long Term Care						
12. Credit A&H						
13. All Other A&H						
14. Total Accident and Health						

NOTE TO PART I: Exclude all non-Utah business, administrative services only (ASO), administrative services contracts (ASC), self-funded plans, or other non-underwritten business. If Comprehensive Hospital & Medical is reported, part III must also be completed. If Long Term Care or Medicare Supplement is reported, part II must also be completed. Line 14 in part I must balance with the total accident and health premium and losses reported on the Utah State page of the Annual Statement. The survey filing will not be complete unless the survey matches the Utah State page.

PART II: UTAH INSURED LONG TERM CARE & MEDICARE SUPPLEMENT BUSINESS ONLY (ROUND TO NEAREST DOLLAR)

	I	II	III	IV	V	VI
LONG TERM CARE	NUMBER OF INSURED MEMBERS	NUMBER OF INSURED POLICIES	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
1. Individual						
2. Group						
MEDICARE SUPPLEMENT						
3. Medicare Select						
4. All Other Medicare Supplement						

NOTE TO PART II: Exclude all non-Utah business, administrative services only (ASO), administrative services contracts (ASC), self-funded plans, or other non-underwritten business.

PART III: UTAH INSURED COMPREHENSIVE HOSPITAL & MEDICAL BUSINESS ONLY (ROUND TO NEAREST DOLLAR)

	I	II	III	IV	V	VI
INDIVIDUAL	NUMBER OF INSURED MEMBERS	CUMULATIVE MEMBER MONTHS	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
1.1 Health Maintenance Organization						
1.2 Preferred Provider Organization						
1.3 Point of Service						
1.4 Indemnity / Fee for Service						
1.5 Other plan types						
1.6 Total Individual Business						
SMALL GROUP (2 to 50)						
2.1 Health Maintenance Organization						
2.2 Preferred Provider Organization						
2.3 Point of Service						
2.4 Indemnity / Fee for Service						
2.5 Other plan types						
2.6 Total Small Group Business						
LARGE GROUP (51 or more)						
3.1 Health Maintenance Organization						
3.2 Preferred Provider Organization						
3.3 Point of Service						
3.4 Indemnity / Fee for Service						
3.5 Other plan types						
3.6 Total Large Group Business						
CONVERSION						
4.1 Health Maintenance Organization						
4.2 Preferred Provider Organization						
4.3 Point of Service						
4.4 Indemnity / Fee for Service						
4.5 Other plan types						
4.6 Total Conversion Business						
5.0 Grand Total Comprehensive						

NOTE TO PART III: Exclude all non-Utah business, administrative services only (ASO), administrative services contracts (ASC), self-funded plans, or other non-underwritten business. Line 5.0 in part III must balance with the total comprehensive hospital & medical data reported on line 1 in part I.

PART IV: ADMINISTRATIVE SERVICES FOR UTAH MEDICAL PLANS ONLY (ROUND TO NEAREST DOLLAR)

	I	II	III	IV	V	VI
SELF-FUNDED MEDICAL PLANS	NUMBER OF MEMBERS	ADMIN. INCOME	CLAIM ACTIVITY			
6.1 Health Maintenance Organization						
6.2 Preferred Provider Organization						
6.3 Point of Service						
6.4 Indemnity / Fee for Service						
6.5 Other plan types						
6.6 Total Self-Funded Medical						
INSURED MEDICAL PLANS						
7.1 Health Maintenance Organization						
7.2 Preferred Provider Organization						
7.3 Point of Service						
7.4 Indemnity / Fee for Service						
7.5 Other plan types						
7.6 Total Insured Medical						
8.0 Total Administrative Services						

NOTE TO PART IV: Include administrative services only (ASO), administrative services contracts (ASC) and other non-underwritten administrative business related to self-funded and insured medical plans only. Exclude all non-Utah business and all insured (underwritten) accident and health business.